Texas Healthcare Transformation and Quality Improvement Program

REGIONAL HEALTHCARE PARTNERSHIP (RHP) 10
Annual Anchor Report: Appendices

December 15, 2015

Region 10 RHP

Appendices: Table of Contents

Appendix A: Project Highlights

Methodist Mansfield Patient Impact Story
ED Navigation Project

Patient X is lives in Texas with an average of 2 Emergency Department visits per month prior to the intervention of ED Navigator.

After meeting with the patient navigator, the patient disclosed that they had limited transportation, making it a challenge for them to get to appointments with providers in Fort Worth or Dallas. They were unaware of local PCPs that would be more convenient to reach. The patient also did not have a primary care provider or access to specialists needed to help them manage their chronic pain and illness. Thankfully, the ED navigator was able to locate area PCPs and specialists and offered to make appointments for the patient. The patient was also educated on appropriate ED utilization and alternatives to returning to the ED.

During the patient navigator's one week follow up with the patient, the patient had already selected a local PCP, set up an appointment and had already visited the referred specialist physician. This patient is well on their way to managing their chronic illness and getting the care that they need in a setting more appropriate than the Emergency Department!

JPS Breastfeeding Project Patient Impact Stories

A Hispanic woman was referred to me from outlying clinic due to mastitis diagnosis and treatment from JPS Urgent Care. Mother arrived with severe nipple trauma and mastitis diagnosed. During the lactation evaluation it was noticed that the baby had a short frenulum and a severe heart shaped tongue which was causing the nipple trauma and then in turn causing the mastitis. The mother was given First Aid for cracked and bleeding nipples. I suggested position changes, and provided assistance with latching her infant at the breast. I provided a referral to the Pediatrician for evaluation. The baby was gaining weight, and milk exchange was 132 grams with this feeding. I saw her for follow up visit and mother reports that there is still tremendous pain with nursing and nipples were healing but very slowly. A nipple shield was given, and the mother continued to nurse because it helped with the pain and the Pediatrician had given the mother a referral to ENT clinic to evaluate the tongue for short frenulum. On the next visit the mother returned in tears for another appointment and was ready to give up, so I contacted WIC and started the process to attain a double electric pump in order to allow the nipples to rest so that they could heal. The mother continued to pump and feed expressed breast milk to the baby by bottle until the next scheduled appointment. During this time of resting her nipples, a Community Care Partner was sent to do a home visit to touch base with the mother, follow up with breastfeeding education, and provide support to help the mother continue to breastfeed despite the roadblocks. Following the last appointment, where the Frenectomy was performed, the mother requested a visit to teach the baby how to latch again so that the mother could feed the baby by breast. During the appointment, the baby was able to re-latch and get 76 grams of breast milk transferred. The mother reported the latch as being "much more comfortable". At her

follow-up postpartum visit, the notes stated that she was still exclusively nursing at 9 weeks with mastitis completely healed and no further nipple trauma.

I received a referral from a Community Care Partner; she reported that this baby couldn't get latched on to the right breast and that she tried all the things that she knew and was concerned due to the desire of the mother to exclusively breastfeed. In the breastfeeding history that I took, the mother stated that she had an augmentation. She had a WIC double electric pump and had been using it to get a small amount of milk from each breast. When a milk exchange was evaluated, there was no milk exchange, even with the nipple shield. We discussed all options from Supplemental Nursing System to Paced feeding. I helped mother cope with the reality of needing to supplement after nursing due to surgery and most likely the poor glandular tissue and truly not able to make milk. It was so beneficial for the Community Care Partner to see her and catch the variation before the mother attempted to exclusively breast milk feed her infant and encounter problems with the infant not getting enough breast milk volume and not have adequate weight gain.

This potential problem was noticed by a Community Care Partner and the baby received adequate formula to grow. Mother was able to process that baby was unable to be exclusively breastfed but able to take in as much expressed breast milk that mother pumped. She was given a pumping plan and an office number for any questions. She was encouraged to put baby to breast as much as possible.

A mother was referred to me by a Community Care Partner, and was unable to wake baby to eat and the baby had only 1 stool in the last week. Mother was doing mixed feedings and wanted to stop the

formula so the Community Care Partner referred her to me to evaluate. The mother's anatomy showed that the baby wouldn't open wide enough to get all the nipple in to be able to get the milk transfer. The baby had continued to lose weight; the baby's birth weight was higher than the current weight after 8 days. Due to the mother's anatomy, baby needed to be supplemented and mother connected with WIC to get a double electric pump to protect milk production until baby mouth grows, to be able to latch on to the breast. Baby was started on a supplement plan, hopefully with expressed breast milk. This plan will help the baby gain and prevent failure to thrive.

A mother was referred to me by a Community Care Partner. She was a 3rd time breast feeder and had a tender area on her left breast resulting in positioning problems. This mother had been recently diagnosed with mastitis and was being treated with antibiotics. The mother was doing mixed feedings and not emptying her breast for several hours. Education was done on how she is to empty her breast every 3-4 hours to prevent milk from backing up in the milk ducts. The treatment plan included correct positioning and latching infant with the use of a nipple shield to provide good emptying of the breast. Baby received a 48 gram milk exchange and mother reported that her breast felt softer and more comfortable. Mixed feedings were discouraged to prevent a recurrence of plugged ducts. If mother follows the treatment plan a recurrence of mastitis can be avoided.

The most recent mother I saw had a baby that was small for gestational age and a late preterm. The baby was referred at 7 days and was exclusively breastfeeding many times a day with pumping and supplementing expressed breast milk given by spoon. Mother had painful nipples while nursing, so nursing was not a pleasant experience. Mother and Father were very committed to breastfeeding and were very worn out and exhausted and about to give up. Baby had lost weight from discharge and only received a small amount of milk exchange with a nipple shield. I started the mother on a pumping program with a recommendation to rent a hospital grade pump to provide the most stimulation and emptying. The feeding plan given advised nursing every 2-3 hours for up to 30 minutes each side. Followed by pumping after and feeding baby expressed breast milk in bottle with paced feeding. To feed as much as the baby would take and then to follow-up in 1 week. When they returned one week later, larger nipple shield was used and baby was able to open wider and accommodate it and was able to widen the gap to get a deeper latch and increased milk exchange greatly. They had rented a hospital grade pump and were able to supplement with expressed breast milk and baby had gotten beyond birth weight and nursing better at the breast as well at 2 week mark. Mother was more rested and felt pretty confident. Mother requested another visit in one week to see if the supplement could be cut down and possibly remove the nipple shield. The couple returned one week later and the baby was still using nipple shield and got a large milk exchange with a weight gain of 7oz in 1 week. That late preterm baby was given the opportunity to breastfeed due to the intervention and mother's milk supply was increased and protected.

JPS Transition Management Program

Pt's dad: "I truly feel the care and concern she (Jessica R) has for my son and hope to meet her in person so I can hug her and thank her properly. When she has talked to me, I really feel like this isn't just a job for her and she sees my son as a person who needs help and does everything she can to do that- your operation over there and this program is top notch".

Integrated Health Care Initiative
MHMR Health Care Transformation Initiative

MHMR Tarrant is participating in a 5-year waiver program that is designed to transform health care in our communities and improve access to quality, affordable care.

This Integrated Health Care initiative will serve 885 individuals with severe mental, developmental and addictions disorders who also may be homeless and who are not otherwise able to access primary care and/or behavioral health services. MHMR has partnered with JPS Health Network to co-locate primary care and behavioral health services at MHMR's homeless services clinic.

Through this collaboration MHMR and JPS are able to manage the delivery of seamless, well-coordinated care to better serve the homeless population. This integrated initiative is based on the National Council for Community Behavioral Health's (NCCBH) Four Quadrant Clinical Integration Model; providers share the same facility and operations (scheduling appointments, medical records, etc.); regular face-to-face communication; regular treatment team meetings; and are part of a team.

Between August 2014 and February 2015, 220 individuals have received integrated behavioral health and primary care services at the MHMR Homeless Clinic. Many suffer from chronic conditions such as hypertension, diabetes and COPD. Services include care coordination by a Registered Nurse which has impacted emergency room visits, integrated case management, medication reconciliation and smoking cessation services.

My Story by Sara

I spent the first half of 2013 knowing that there was a problem and trying to find somewhere to help address the feelings. That is until I called the crisis line. Not only was there somewhere that wanted to help, but cared enough to send someone to me. Over the next four months they helped me with medication, appointments and stays in facilities. Things would go alright for a while only to break down all over again. My case manager was always only a phone call away. My days turned into an endless cycle of drink, eat, throw up, go buy more, and repeat…On the verge of total meltdown, I took everything I could fit in the car and took off.

February brought about the first tangible positive notes. My housing came through, and I again had a real roof over my head. It also brought about the beginning of individual counseling and peer support for my substance abuse. Since 2015 I have been attending smoking cessation classes.

All this while, I knew that I had health issues that needed to be addressed, but either I blew off the appointments because it was too much hassle to get to them, or there was just no way to get from point A to point B. I was so grateful when JPS opened up in the MHMR Homeless Clinic. Since I was up there more than half the week, I could actually schedule doctor appointments and keep them. I didn't have an excuse to avoiding taking care of my physical health anymore. A

year ago, I weighed 88 pounds, since receiving physical health services, I recently weighed in at 105 pounds.

Today I can look in the mirror and can be ok being me.

If you have any questions or need addition information, contact:
Karyssa Walsh, Program Manager Email: Karyssa.Walsh@mhmrtc.org Phone: 817-569-4159

JPS vs CLABSI
January 8th, 2015

The incidence of a deadly bloodstream infection has been cut in half at JPS by the efforts of a hospital-wide team to uncover why they occur and put preventive practices in place. November marked the third time in the last 10 months John Peter Smith had no central line-associated bloodstream infections.

Known as CLABSIs, central line-associated bloodstream infections occur when bacteria invade the body via a central line — a catheter surgically inserted into a major vein to allow rapid delivery of medications, fluids and nutrients for patients unable to ingest them any other way. The tip of the catheter sits near the heart, so invading organisms move quickly into circulation, becoming widespread.

CLABSIs are among the most common — and most deadly — infections that patients acquire in U.S. hospitals. The federal government is focusing on CLABSI prevention, attaching financial incentives for the first time last year, because they can be prevented, potentially saving thousands of lives and billions in healthcare spending.

Armed with funding from the state's Medicaid 1115 Waiver, a JPS team led by infection control nurse Mickie Wright began analyzing electronic medical-record data in 2012, digging for root causes of CLABSI at JPS and finding potential for process improvements.

Changes adopted since then include daily chlorhexidine baths for all ICU patients and, for all units, standardized dressing-change procedures and a color-coded system for supplies and caps on central-line ports. Nurse Managers are automatically alerted when a patient has had a central line for more than seven days. In those cases, the patient's physician is asked to consider whether the continued need for it outweighs the infection risk. Designated nurses review each central line every Monday.

Updated hospital policy on central line insertion and care is in the works, as is a CBL that will become mandatory for nurses.

"It's going to be a never-ending process," said Wright, "as it should be. We should always be evaluating what's working well and what could be working better."
The number of infections per month was as high as seven in June, 2013. It has been lower than three since May, 2014.

At the project's outset, the rate of CLABSIs was 1.72 per 1,000 catheter days. In fiscal year 2013, the rate dropped to 0.9. It dropped to 0.7 in FY 2014. By the beginning of FY 2015 (in October, 2014,) it was down to 0.2.

Members of the CLABSI team include Wright, Heather Scroggins, Heather Bright, Renee Montgomery, Bobby Coleman, Debi Zafer, Kim Perkins, Melissa Cook, Amanda Lewis, Sheri Snow and Dana Nichols. Aubrie Augustus is the project's executive sponsor, Dr. Mark Oltermann is the medical sponsor and Greg Fuhrmann is the Innovation and Transformation Center coach.

Appendix B: Learning Collaborative Measures (Presented at the Clinical Quality Committee Meeting)

LEARNING COLLABORATIVE

RHP 10

Improvement progress, Care Transitions and Behavioral Health shared measures

Vincent Do, BSIE, LSSMBB, LBC– *Sensei*
Sr. Performance Improvement Specialist

LEARNING COLLABORATIVE

The role of shared measures reporting

Learning Collaborative

=

Best practices

+

measureable improvement

+

cross-organization learning

What we will cover

- Update on Collaborative teams
- Wins
- Reporting progress of LC overall
- Plan for shared measures

Care Transitions shared measures

Number of teams reporting

Care Transitions - Inpatient – 5 teams

- Texas Health Resources - Fort Worth
- Baylor Health Care System
- JPS Health Network
- UNT Health Science Center
- Wise Regional Health System

Care Transitions - Outpatient – 2 teams

- MHMR Tarrant County
- UTSW/Moncrief Cancer Institute

Wins

Total interventions achieved for 2014 and 2015

- Care Transition - Inpatient: 49,369
- Care Transition - Outpatient: 1,614

Wins

Intervention rate for 2014 and 2015

- Care Transition - Inpatient:
  - Increase from 64% to 70%
- Care Transition - Outpatient:
  - Increase from 65% to 88%

Care Transitions - Inpatient

Collaborative (2 of 5 Teams): Percentage discharged patients who received written discharge summary

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Value	97%	96%	97%	95%	96%	96%	96%	97%	97%	96%	96%	97%	97%	96%	96%	97%	97%	97%	96%	96%
Median	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%	96%
Goal																				
Numerator:	1291	1491	1462	1458	1337	1598	1604	1615	1610	1496	1603	1522	1332	1545	1501	1559	1600	1548	1474	1498
Denominator:	1336	1555	1515	1530	1392	1668	1679	1672	1661	1551	1641	1576	1375	1602	1569	1614	1651	1595	1535	1554

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
96%	97%	16,565	13,579	30,144

Care Transitions - Inpatient

LEARNING COLLABORATIVE

Collaborative (2 of 5 Teams): Percentage discharged patients whose follow-up provider rec'd summary within 7 days

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Value	7%	11%	38%	49%	35%	28%	50%	63%	55%	79%	82%	62%	100%	74%	88%	71%	74%	37%	51%	53%
Median	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%	54%
Goal																				
Numerator:	26	52	182	251	155	110	207	298	292	384	425	320	384	384	443	378	413	180	257	261
Denominator:	391	492	482	512	382	400	416	470	534	484	521	514	385	522	504	533	555	491	462	490

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
46%	67%	2,362	3,000	5,362

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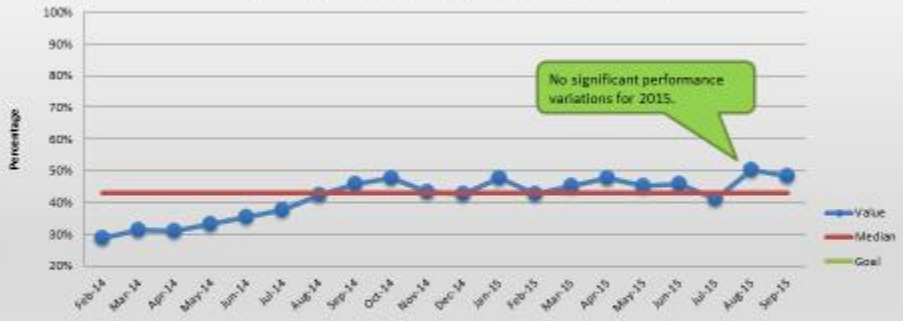
Care Transitions - Inpatient

LEARNING COLLABORATIVE

Collaborative (4 of 5 Teams): Percentage discharged patients with community provider contact within 7 days



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Value	29%	31%	31%	33%	35%	38%	42%	46%	48%	43%	43%	48%	43%	45%	48%	45%	46%	41%	50%	48%
Median	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%	43%
Goal																				
Numerator:	398	488	478	513	503	638	742	796	833	711	722	778	652	821	826	785	821	670	872	816
Denominator:	1378	1555	1549	1551	1417	1700	1749	1740	1751	1642	1690	1632	1530	1811	1737	1745	1786	1655	1740	1690

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
38%	46%	6,822	7,041	13,863

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Care Transitions - Outpatient

LEARNING COLLABORATIVE

Collaborative (2 to 3 Teams): Percentage who are provided health education materials related to health condition.

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Value	14%	10%	32%	36%	54%	96%	99%	97%	55%	58%	71%	94%	67%	90%	73%	61%	92%	94%	92%	92%	76%
Median	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%	73%
Goal																					
Numerator	7	4	19	23	29	71	75	62	37	45	84	78	43	28	22	55	47	32	44	57	41
Denominator	50	42	59	64	54	74	76	64	70	77	119	83	64	31	30	57	51	34	48	62	54

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
64%	81%	534	349	883

Care Transitions - Outpatient

LEARNING COLLABORATIVE

Collaborative (2 to 3 Teams): Percentage who received contact with follow-up care coordinator team within 30 days of health material dissemination to follow up with its use of information.

	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Value	20%	50%	88%	79%	76%	68%	65%	61%	57%	74%	70%	71%	100%	78%	100%	100%	100%	100%	100%	100%	100%
Median	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	78%	
Goal																					
Numerator	1	2	7	11	28	25	54	57	28	14	44	60	55	21	59	44	37	47	66	42	51
Denominator	5	4	8	14	37	34	83	94	49	19	63	84	55	27	39	44	37	47	66	42	51

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
67%	94%	329	402	731

Behavioral Health shared measures

Number of teams reporting

Behavioral Health – 4 teams

- MHMR Tarrant County
- Baylor Health Care System
- JPS Health Network
- Wise Regional Health System

Wins

Total interventions achieved for 2014 and 2015

- Behavioral Health: 177,155

Wins

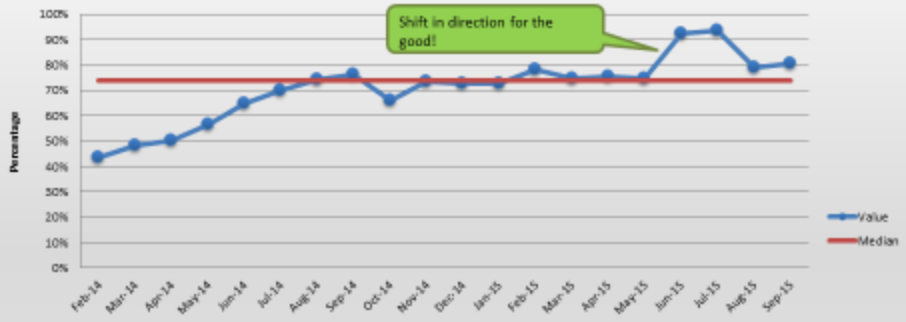
Intervention rate for 2014 and 2015 YTD

- Behavioral Health:
  - Increase from 46% to 49% ↑

Behavioral Health

LEARNING COLLABORATIVE

Collaborative (4 Teams): Percentage patients screened with cross-specialty tool



	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Value	43%	48%	50%	56%	65%	70%	74%	76%	66%	73%	73%	75%	78%	75%	76%	75%	92%	93%	79%	81%
Median	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%	74%
Numerator	1213	1517	1734	2041	2852	5990	4678	5519	4937	5428	6599	6277	5942	6746	7095	6259	5704	7401	6970	7564
Denominator	2790	3151	3445	3622	4366	5696	6318	7240	7464	7409	9088	8654	7583	9048	9394	8379	6170	7918	8827	9370

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
67%	80%	40,488	59,956	100,444

Behavioral Health

LEARNING COLLABORATIVE

Collaborative (4 Teams): Percentage of patients who received integrated care intervention in past 12 months

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Value	8%	7%	7%	6%	6%	7%	9%	11%	6%	10%	16%	9%	9%	9%	9%	11%	12%	11%	9%	9%
Median	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%
Numerator	202	197	249	217	271	425	547	770	452	765	1455	759	642	821	891	880	718	872	820	835
Denominator	2656	2996	3375	3562	4304	5658	6258	7108	7362	7290	8941	8552	7496	9521	9536	8301	6092	7836	8768	9304

2014 Performance	2015 YTD Performance	2014 Interventions	2015 Interventions YTD	Total Interventions: 2014 - 2015 YTD
9%	10%	5,526	7,236	12,762

Behavioral Health

LEARNING COLLABORATIVE

Collaborative (3 Teams): Percentage patients whose condition improved with intervention

	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Value	62%	66%	65%	69%	70%	67%	52%	52%	54%	56%	59%	62%	59%	62%	69%	71%	69%	67%	67%	67%
Median	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%	65%
Goal																				
Numerator	3098	3339	3314	3674	3696	3521	2595	2560	3025	2814	2818	2851	2958	3078	3579	3719	3676	3375	3216	3048
Denominator	5001	5097	5113	5340	5244	5234	5087	4956	5582	5044	4749	4629	5082	4990	5208	5230	5357	5040	4787	4565

2014 Performance	2015 YTD Performance	2014 Patients Impacted	2015 Patients Impacted YTD	Total Patients Impacted 2014 - 2015 YTD
61%	66%	34,454	29,495	63,949

LEARNING COLLABORATIVE

Plan for shared measures

- Continue monthly reporting
- LCC will continue to have 1:1 with collaborative for best practice sharing
- JPS anchor offers data TA as requested